August 4, 2003.

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

MDR Tracking #: M2-03-1283-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Orthopedic Surgery. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___, a 35-year-old male, was injured at work when he slipped, fell, and landed on his back. Following this slip and fall, he had immediate pain and muscle spasm in his back. He was taken to the ___. They examined him and gave him medication for pain and muscle spasm. He was sent back to limited duty work. The pain became progressively more severe. On June 19, 2002 he consulted ___, an orthopedic surgeon, who did x-rays that demonstrated narrowing of the interspaces at L3/4, L4/5 and L5/S1. He then treated him with physical therapy and medication for pain, muscle spasm and anti-inflammatory medication. His improvement was quite slow and he did an MRI that demonstrated multiple level degenerative changes. In fact, he had four-level degenerative disc changes on the MRI. These involved the L2/3, L3/4, L4/5 and the L5/S1 joints. ___ gave him epidural steroid injections. He was scheduled to have three, but after the first two he did not get any relief, so ___ stopped the third one.

The patient then had a provocative lumbar discogram followed by a CT scan. Again, the CT scan demonstrated multiple joint problems in his lumbar spine. The radiology report by ___ dated February 19, 2003 states that he had annular ligament tears with etravasation of contrast material at L2/3, L3/4, L4/5 and L5/S1. Therefore, he has four-level disc disruption in his lumbar spine. His MRI reported a 3 mm disc herniation to the left at L2/3, a 1.5 mm disc bulge at L3/4 which was his most normal appearing disc, and a 3 mm central disc herniation at L4/5 with 50% of the foramina being narrowed due to facet hypertrophy and bulging annulus. At L5/S1 he had a 4 mm central disc herniation with indentation in the dural sac.

REQUESTED SERVICE

___ has proposed a two-level IDET procedure on this patient at L4/5 and L5/S1.

DECISION

The reviewer agrees with the prior adverse determination.

BASIS FOR THE DECISION

This patient does not fall into the category that would be helped by a two-level IDET procedure, according to the criteria given by ___ in their 2000 Spine article. The patient has evidence of four-level problems in his back and the discs are not well contained. There is evidence of neural compression on the imaging studies. The patient would not get a good result from the proposed procedure.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10

days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 4th day of August 2003.